OFFICE OF THE
HEALTHCARE ADVOCATE
STATE OF CONNECTICUT

Testimony of Kevin Lembo, State Healthcare Advocate
Before the Human Services and Appropriations Committees
On the Department of Social Services' 1915(b) Managed Care Application
March 31, 2009

Good morning Senator Doyle, Representative Walker, Senator Kane, Representative Gibbons, Senator Harp, Representative Geragosian, Senator Debicella, Representative Miner and members of the Human Services and Appropriations Committees. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to offer testimony on the need, at minimum, for substantial revisions to the Department of Social Services' (DSS) application to the Center for Medicare and Medicaid Services (CMS) for a new 1915(b) waiver for the HUSKY A program. Accountability is the watchword this year, and accountability is something that you can ensure by being proactive on this waiver application by demanding substantial modifications. Too often we've relied over the years on representations from officials about the adequacy of the HUSKY program. These assurances aren't enough anymore. We need performance. While the legislature has moved to Results Based Accountability in budgeting, we need this same accountability with HUSKY. The measures that have been used to evaluate the success of HUSKY are not designed to capture the most important information about the program.

My office makes suggestions for the revisions of some of these measures, most of which must be incorporated into the waiver application itself to ensure meaningful evaluation and the availability of such evaluations for public scrutiny. What OHA suggests is the same kind of accountability for performance that you expect from any other state agency or program. The size of the DSS budget and the $800 million HUSKY A program demand much greater scrutiny than we've already given them. For instance, in the last few years, the department has made a series of missteps, despite assurances of accountability, that call for even greater and enforceable accountability now.[1]

[1] While some of these missteps have occurred outside the HUSKY program, they are indicative of a larger accountability problem that provides evidence for including additional accountability requirements in the HUSKY A waiver application.

Examples of these missteps include:

1. Pairing HUSKY and Charter Oak in provider contracting. This pairing was not required by statute but DSS made it a requirement in the RFP, and the department failed to compromise for nearly a year.
    - *Concerns were expressed about this strategy in early 2008 – the failure to delink the two programs for provider recruitment delayed much needed access to care for HUSKY enrollees.*
2. Failure to re-bid the HUSKY contracts after the department finally agreed to separate the HUSKY and Charter Oak provider network enrollment.
    - *The Attorney General, OHA and the Office of the Child Advocate advised the department that the procurement process needed to be reinitiated, but the department ignored the advice – this put the department in legal jeopardy.*
2. Negotiation of MCO capitation rates that incorporated an effective increase of 24% with no evidence showing need for such an increase
    - *We are still waiting for the results of the audit of the HUSKY program.*
    - *The results may show the need for further accountability on the MCO capitation payments.*
3. Continued problems with Charter Oak—access continues to be poor.
    - *Creating a health plan is a noble thing, but basing reimbursement on Medicaid adult fee schedules has translated into very limited access to providers and hospitals.*
    - *Most hospitals are not enrolled*
4. A drive to return as soon as possible to the fully-capitated managed care arrangement at the expense of recipients' care.
    - *The department was so anxious to terminate the ASO arrangements, that there was no consideration given to the potential of success of an ASO arrangement alongside the MCO system.*
5. Related to #4, there was no evaluation of the ASO arrangement in terms of cost, access, utilization and outcomes in order to determine whether the ASO process should have been kept in place instead of rushing back to the fully-capitated managed care arrangement.
    - *Neither Federal nor State law requires that a fully-capitated managed care arrangement be in place.*
    - *In fact, several delivery systems can co-exist simultaneously.*
6. General intransigence when requested to share draft regulations with Medicaid Managed Care Council (MMCC) that directly affect HUSKY recipients, despite the MMCC's duty to make recommendations on changes to the HUSKY A program – e.g. EPSDT scheduling assistance regulation essentially died once its flaws were exposed after attorneys on the MMCC shared the draft regulations with the rest of the MMCC.
7. Lack of accountability on the Katie Beckett waiver. Our office researched this issue and found that most children on the waiver use only traditional Medicaid services.
    - *The department has not proposed a more efficient, cost effective and flexible design to allow for the availability of waiver services for the neediest people.*
8. Continued failure to have an adequate process by which to identify Children with Special Health Care Needs (CSHCN)

- *Many children are not enrolled in the Katie Beckett waiver, affiliated with Title V or with DCF, but still have special healthcare needs.*
- *Continued failure to coordinate with DPH on CSHCN for Title V funds.*

9. Consistent failure to report on utilization of actual services by categories for the last few years, whether it's HUSKY A, HUSKY B, SAGA or Charter Oak so that there could be real accountability if access and utilization aren't up to acceptable levels.
10. Failure to regularly conduct secret shopper surveys despite poor results of the previous Mercer survey on provider availability and timeliness of appointments in HUSKY A.
11. Failure to conduct a truly independent evaluation of the HUSKY program.
    - *Mercer is not an independent entity. It performs the actuarial studies for the department, it collects the encounter data and has a vested interested in the adequacy of its rate setting.*
    - *CT Voices does some independent monitoring but has not been given the opportunity or resources to conduct complete, annual evaluations of the entire program.*
12. Primary Care Case Management (PCCM)–the proposal in the waiver flouts the plan put in place by the legislature for a statewide program to compete alongside the fully-capitated managed care program.
13. Failure to follow clear statutory provisions that require:
    - *Incorporating SAGA into Medicaid*
    - *Following through on obtaining a family planning waiver*
    - *Reimbursement for medical interpretation services*
    - *Timely initiation of PCCM.*
14. Inclusion of new budget proposals that are based on incorrect interpretations of current federal law or are contrary to public policy such as:
    - *Impeding access to and exerting excessive control of utilization of dental services for children after a settlement of an eight year-long litigation that has begun, finally, to increase the number of participating dental providers in the program and to address the long-term pent up demand for services.*
    - *Imposing requirements such as premiums for HUSKY A and self-declaration of income that would jeopardize federal stimulus money.*
15. Failure to recoup from Medicare drugs costs of up to $27 million paid through the Medicare Part D wrap-around because the DSS did not adequately pursue the exceptions process for denials of non-formulary drugs.

General Comments

Accountability goes beyond assurances from DSS to the federal government in a waiver application, and access to documents through the Freedom of Information Act.[2] It requires actual performance -- the job must get done, and it must get done right.

The bullets above provide more than enough rationale for your extraordinary vigilance in scrutinizing the waiver application and the ongoing program. At a time like this, when we are struggling financially, we also should be eager to foster statewide competition with the

[2] Though the federal government does not require the state to provide more than assurances in its waiver applications, the basis for those assurances and the mechanisms for monitoring of the state's performance should also be included.

MCO arrangement by allowing ASO and statewide PCCM arrangements. **DSS actually expects PCCM costs to be less than those for MCOs because of MCO administrative costs.**[3] This provides even more of a basis for allowing expansion of PCCM and for slowing the rush to approval of the waiver.

At minimum, the fifteen examples above militate for the inclusion of more accountability in this waiver application via reporting of actual utilization of services, the performance of secret shopper surveys, etc. as described below, and the documentation of access to care. Access to care and good outcomes for recipients should be the most important goals of HUSKY A. These goals can be met while maximizing efficiency and scrutinizing costs.

Specific Observations and Recommendations for Modification of the Waiver Application

1. Because the waiver application is crafted as an initial waiver application, it doesn't have to include descriptions of the previous operations of program -- this is a bit deceptive – it is not illegal, but it doesn't give the full picture of the program over the years. More description should be provided about the previous operation of the program, including the temporary transition to ASOs or PIHPs last year and a more description of the carved-out programs.
2. This is an $800 million program – it needs more independent assessment. Secret shoppers and independent evaluations must be conducted every year without fail.
    - *Page 31 of the waiver application – DSS says Mercer is an independent external review organization.* ***Mercer is NOT independent—it sets the cap rates and is responsible for collecting encounter data.***
    - *Page 79 – only $100K is allocated for independent assessment. This seems inadequate to accomplish a complete evaluation of the program*
    - *The Department should consider yearly or biennial independent assessments of the entire program, including the evaluation of general and timely access to care across primary care providers and specialists of all types.*
3. It is not clear that the Medicaid FFS (fee-for-service) network is available for dental and Behavioral Health Partnership (BHP) services. Providers can be enrolled in the BHP and BeneCare's dental network without being enrolled in FFS.
4. According to CMS, when evaluating managed care network sufficiency, it doesn't require that DSS check actual provider availability. CMS may change its evaluation process, but we should not take the chance – we should build requirements into the waiver application for real access measurements on a frequent basis.
5. DSS does not require actual reports from the MCOs on the timeliness of care received for each service to determine if contractual requirements are actually met. Reports must be part of the evaluation.

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[3] "It is assumed that savings generated by the PCCM pilot program will offset the PCCM case management fees, additional administration costs, and anticipated increases to utilization. The savings is assumed to be generated by eliminating the MCO non-medical load built into the capitation rates." (See waiver application, multiple locations.)

6. No assessments are done to ensure children's ongoing treatment needs are met – waiver application p.26 says otherwise, but care coordination statistics from previous years show only approximately 2% of recipients get any kind of care coordination.
7. Also see waiver application p.26 - waiver application mentions coordination of listings of Children with Special Health Care Needs, but there's no evidence this has ever happened, plus there are other eligible children not identified through file exchange with DPH. There is no attempt to reach otherwise eligible children.
    - *OHA has first-hand experience with these cases.*
8. Part B waiver application – Monitoring tools starting on page 57 – there is an acknowledgement that most monitoring is by consumer self-report. The following monitoring needs to be described in more detail and performed regularly and independently:
    - *Disparities – only quality of care measured.*
    - *No periodic comparisons of the number of providers.*
    - *Utilization Review—no review of grievance process.*
9. Pages 61-62, only "accreditation" measure of MCO is CAHPS which is a consumer survey instrument and not a real time measure. We have found that the CAHPS does not reflect access measures accurately.
10. Page 62 – DSS cites an Access database for tracking complaints. These reports should be produced every month for the Medicaid Managed Care Council (MMCC). MCO required tracking (page 63) should be compared to DSS tracking and MCO reports should also be shared monthly.
11. Page 64 – PCP/Specialty Access Reports – The current reports are not detailed enough, are only done quarterly and do not measure whether provider panels are limited.
12. Page 64 - case management reports. We don't know of any action ever taken by DSS on these reports. Reports are only done semi-annually. This is not frequently enough. Data should be shared with MMCC.
13. Page 64 – same comment for PA requests, etc.
14. Page 66 – Network adequacy assurance as written is insufficient. Assurance does not equal performance. See comments on the need for secret shopper surveys.
15. Cost-Effectiveness – page 78. Hospice is included in cost effectiveness projections from 7/1/09 on, but the Governor's budget proposal eliminates hospice.
    - *Need to be cognizant that there may be money allocated to hospice services in projected cap rates – **if service is eliminated that money becomes available and should not go to MCOs.***
16. Stop-loss – page 82 – DSS does NOT require MCOs to have stop-loss.[4] **Failure to require stop-loss coverage or re-insurance coverage may encourage MCOs to deny catastrophic claims more frequently or to impose stricter requirements and administrative burdens in order to obtain coverage for these claims.**

[4] "The State requires prior notification from the MCOs as to their intent to purchase or modify reinsurance protection, but does not require MCOs to purchase private reinsurance coverage. The risk analysis, assumptions, cost estimates and rationale supporting the proposed reinsurance arrangement is required for prior approval by the State."

- *This is particularly problematic in the case of Community Health Network of Connecticut, Inc., where the additional complicating issue of the non-profit status makes the state the de-facto reinsurer.*

17. Page 87 –dental utilization trend projected at 25%. That trend does not include the Governor's proposed prior authorization requirement on kids' services. Since DSS has already projected the costs without a prior authorization requirement, there's no reason to lower that projection. The trend should be high given the settlement of the litigation. This is a positive development.
18. Page 93 – why is there no effort to increase Third Party Liability (TPL) recoveries? This would be a cost-savings to the program.
    - *OHA often saves the state money by exhausting coverage under commercial plans before allowing HUSKY to kick in.*
    - *DSS needs to produce the number of enrolled HUSKY recipients with commercial insurance*
    - *DSS needs to ensure that it is not paying for expenses that commercial insurers should bear.*
19. Last two pages of appendix, see Excel spreadsheets with base year capitation rate and adjusted waiver year one and two capitation payments. Base year (2007) = $234 per member per month; Waiver year 1= $317; Waiver year 2= $337.
    - ***The adjustment between base year and projected year one of the waiver (SFY 2009) is a 35% increase in per member per month (PMPM) costs! (Even though dental trend is 25%, there are not enough total/expensive dental services to account for that large an increase. We strongly suggest the committees scrutinize this.)***
    - *This is followed by an increase of 6.3% from year one to year two (or 44% from base year.) [Dental = 2.83% program adjustment or $35.87 PMPM, while remainder of program adjustments are 12.76% or $82.98 PMPM for state plan services. For year two there is only a state plan services adjustment of $20.93 PMPM.]*
    - *More detail is needed to justify these numbers.*
20. See also the administrative cost adjustments on these Excel spreadsheets. There is a projected 8.79% increase in year one, or an increase from $6.21 PMPM to $7.66 PMPM.[5] This increase should be evaluated in closer detail.

This waiver application does not need to be approved today. It can be modified with time to spare and resubmitted to the committees for further review. Besides, if changes are made in the budget process, the department will need to submit either state plan amendments or a waiver amendment, just as they did when the program was switched to the ASO arrangements from the fully-capitated managed care model in late 2007.

Your action on the application will be the signal that CMS relies on to decide whether public policy concerns have been adequately addressed. That is why we strongly suggest that you not rush to approve this application without ensuring that all of your questions are answered, no matter how detailed. Legislative approval of a waiver application is used by CMS to justify federal approval, so your approval of this waiver application without any

[5] Perhaps these figures should be evaluated by actuaries at OFA. OHA staff is prepared to meet with the committee to discuss these figures, but we encourage you to ask questions of DSS staff at the hearing.

modification will be viewed as your approval of every detail currently therein. Therefore, I encourage you to delay a vote on this application until you have thoroughly reviewed it and included more accountability measures. You can and should question any financial assumptions. The waiver application can document a requirement that DSS submit more meaningful and specific reporting to the MMCC. I urge you to remember that assurances do not equate to performance. It is perfectly within the legislature's authority to demand performance from this $800 million program.

Thank you for your attention to my comments. As ever, my office stands ready to assist.